UNIVERSITY OF SANTO TOMAS HOSPITAL
España Blvd., Manila 1015
Tel Nos. 731-3001 to 29; http://www.usthospital.com.ph
DEPARTMENT OF MEDICAL EDUCATION AND RESEARCH

Picture Passport size in white background

APPLICATION FORM

Charge Slip No. & O.R. No. / Date

Processing: _____

Admission: _____

Please check the appropriate information and fill out each section; "refer to C.V." is not acceptable
(This form may be photocopied but we will only accept clear reproduction)

TYPE ☐ **Internship** ☐ **Residency** ☐ **Fellowship** ☐ **Observer** ☐ **Non-USTH Rotators**	***SPECIALTY***
PREFERRED DATES FOR OBSERVERSHIP:	*REFERRED BY:*
GIVE DETAILS WHY YOU CHOSE THE SPECIALTY:	
WHY DID YOU CHOOSE THIS HOSPITAL?	

GENERAL INFORMATION

LAST NAME, FIRST NAME, MI		***NICKNAME***	
PRESENT MAILING ADDRESS		***PERMANENT MAILING ADDRESS***	
DATE OF BIRTH	***PLACE OF BIRTH***	***NATIONALITY***	***RELIGION***
CIVIL STATUS, IF MARRIED WRITE SPOUSE NAME, AGE AND OCCUPATION			

NAME OF CHILDREN	AGE	STATUS

CONTACT DETAILS

HOME PHONE	***CELLPHONE NUMBER***	*FAX NUMBER:*	***E-MAIL ADDRESS:***

EDUCATIONAL BACKGROUND

	NAME OF SCHOOL	INCLUSIVE DATES / DEGREE
PRIMARY		
SECONDARY		
PREMED		
MEDICAL SCHOOL		
GRADUATE SCHOOL		

CLASS STANDING AND PHYSICIAN LICENSURE EXAMINATION RESULT

CLASS RANKING	***BOARD RATING***	***DATE PASSED***	***NUMBER OF ATTEMPT***	***PRC LICENSE NUMBER***	***VALID UNTIL***
SPECIALTY / SUBSPECIALTY EXAMS			***DATE PASSED***		***SPECIALTY/SUBSPECIALTY EXAMS***
AWARDS AND ACHIEVEMENTS Include subspecialty examinations					

POSTGRADUATE STUDIES AND HOSPITAL EXPERIENCE

INCLUSIVE DATES	*POSITION*	*INSTITUTION / ADDRESS*

OTHER PROFESSIONAL AND SCIENTIFIC EXPERIENCE WITH DATES (research fellowships, practice, etc.)

RESEARCH PUBLICATIONS *(Enumerate the Titles of Paper, Author(s), Society, Distinction, the Publication & Date Published)*

STATEMENT OF HEALTH MUST BE COMPLETED State of Health (List previous serious illnesses, existing disabilities and limitations)

PROFESSIONAL LIABILITY
Please complete the following questions as part of the credentialing process. Please be prepared to provide substantive information if you answer yes to any of the following questions:
Have you ever been dismissed from or the subject of any disciplinary action, such as admonition, reprimand, suspension or termination? ☐Yes ☐No
Have you ever been the subject of actions resulting from professional misconduct or are there any such cases pending? ☐Yes ☐No
Have there been any settlements or judgments made against you in cases involving medical malpractice or are there any such cases pending? ☐Yes ☐No

PROFESSIONAL AND CIVIC ORGANIZATION	
Membership/Affiliation and Branch/Address	*Period of Affiliation/Membership*

FAMILY BACKGROUND		
PARENTS	*FATHER*	*MOTHER*
NAME		
OCCUPATION		
HOME ADDRESS		
CONTACT NUMBER (S)		
EDUCATIONAL ATTAINMENT		
SCHOOL AND YEAR GRADUATED		

LIST NAMES OF BROTHERS & SISTERS ACCORDING TO AGE	AGE	DEGREE	SCHOOL GRADUATE

CHARACTER REFERENCES *(List 3 references not related to you)*		
NAME	*POSITION/DESIGNATION*	*ADDRESS AND CONTACT NUMBERS*

I pledge to abide by all Rules and Regulations of the University of Santo Tomas Hospital and the provisions of the Memorandum of Residency/Fellowship Training Agreement if I am accepted to the Residency/Fellowship Training program. I declare that the information I have provided is correct and any misrepresentation may be a ground for termination of my training.

_____

Applicant's Signature / Date

Note: Graduate of UST shall submit authenticated supporting documents.